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EDITORIAL

From 1st June 1961 the badge of the Queen's Institute with its familiar monogram VRI, will be awarded for life to nurses appointed to the Queen's Roll. Nurses working for authorities not in membership or affiliation with the Institute will no longer be denied the privilege of wearing their Queen's badge. And those Queen's-trained health visitors, midwives and others who do not wear Queen's nurses' uniform may in future wear the badge.

Until this year, the Queen's nurses' badge has been worn as a badge of office showing that a nurse maintained a standard of service which satisfied the Institute. Since the majority of Queen's nurses now work for local health authorities, supervision by the Institute is no longer appropriate. Some change in the award of the badge was therefore necessary.

We feel this decision will be welcomed by Queen's nurses, who are proud of their badge for the tradition of high service which it has stood for over the past seventy years.

Flashes and epaulettes, however, are another matter. After careful consideration following the poll of opinion taken by superintendents and the recommendations of the Association of District Nurses, the Institute has decided to discard flashes and epaulettes. For some time there have been criticisms about their cost and the fact that they become shabby so quickly; and the poll of opinion showed district nurses two to one in favour of their removal.

There is no historical significance in the flashes and epaulettes which were introduced only fifteen years ago, in keeping with a fashion of the day, which is now becoming outmoded.

Several voluntary nursing associations have expressed dismay at this decision, but we cannot agree with them that the absence of a flash or an epaulette lowers the status of a Queen's nurse. It is by her manner and her work that she is distinguished, and by her badge, which has survived all changes of fashion.

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The author is leader of the Leicester & District Social Club for the Hard of Hearing where he is the senior teacher in lipreading and also undertakes counselling in difficult, individual cases

Deafness in Later Life

by **WALTER H. BLEBY**, B.A.,
Headmaster, Stoneleigh School for Deaf Children, Leicester.

FROM a survey made by the Social Survey Division of the Central Office of Information (Wilkins: 1949) it was calculated that there were 1,765,000 persons over the age of sixteen in England, Scotland and Wales who recognised themselves to be suffering from some degree of deafness. It can be taken as certain that there were a great many more who either did not realise that their hearing was "not as good as it used to be" or who were unwilling to admit it, but who were nevertheless handicapped in some degree. Furthermore it is certain that the numbers have not decreased since 1949, so the problem is far greater than is generally realised.

For the human being the ability to hear speech is of tremendous importance. It is through his hearing that the infant learns the meaning of words and learns to speak; it is through his hearing that he learns to understand the world around him and to adjust himself to other people. Hearing is the main channel through which he receives his education, and for the whole of his life it remains *the* channel by which he can hold his own in society.

Human society is founded on the rapid and easy communication of its members: speech and hearing is the most rapid, most easy, most effective, and most common means of communication. Loss of hearing entails loss of easy communication and consequent loss of social contact.

So the problem is twofold: the loss of hearing itself, and the psychological and social effects of the loss upon the individual.

Hearing Loss

Most cases of deafness in later life are of a mixed type in which three factors play a part:

1. A loss of efficiency in the conducting mechanism of the middle ear.
2. A loss of function in the cochlea.
3. A decrease in the speed of interpretation of what is heard—one facet of the general slowing of mental agility with age.

In so far as the deafness is *conductive* it may respond to medical treatment and it may be considerably helped by a hearing aid. In so far as the deafness is *perceptive* (involvement of the cochlea) it is *not* susceptible to medical treatment and, in almost all cases, it is progressive and steadily blanks out more and more of the hearing for the high-pitched notes.

The effects are: (1) the general level of all the speech-sounds is reduced, and consonant sounds (which are the least physically powerful, and without which speech is unintelligible) become partly or totally inaudible in some conditions; (2) the cochlea no longer responds to the higher-pitched notes, rendering some consonants totally inaudible (since the consonant-sounds lie at the top end of the speech range); and (3) slower mental processes render it much more difficult to interpret the quieter and less complete pattern that is heard.

Psychological and Social Effects

Recognition that something is wrong depends on the kind of situations that are important to the individual. The person who has to depend on hearing speech in more difficult conditions (at a distance, in meetings, in noise, etc.) will feel the effects of a hearing loss earlier than a person whose important situations are generally more intimate.

All of us, however, are more or less adjusted to interpreting speech in difficult conditions when, in fact, quite a proportion of the sounds are inaudible, and since the loss of hearing is generally slow the sufferer usually makes further and unconscious adjustment which can conceal the fact of his loss for a considerable time. Further, the natural human reaction is to avoid admitting a defect in oneself, so the sufferer will blame first other people for "not speaking up", for "muttering", for "whispering to each other (about me)", and may strenuously reject the notion that his hearing is failing.

During this time the sufferer *can* hear "when he wants to"—but at a cost. He must, consciously or unconsciously, devote more and more of his mental energy to interpreting the quieter and imperfect pattern of speech that he is receiving. The price is strain: and attendant irritability which can affect his social relationships.

As the loss increases, and the pattern he hears becomes less and less perfect, he will make more and more mistakes in understanding what is said to him and around him. This leads to confusion and misapprehension in his own mind and increasing difficulties in his relationships with other people. It may also affect his ability to carry out instructions reliably to the extent of endangering his employment, and so add apprehension and worry to his troubles. At the same time people who are in contact with him are finding the normal flow of social give-and-take disturbed by the need to change their habitual manner of speaking, by the need to repeat remarks to make him understand, and by the need to break the flow of thought to correct his misunderstandings: people are finding him "a nuisance" and a strain and are beginning to ignore him and avoid him.

So the pattern is one of increasing strain, worry, irri-

tability, suspicion, misunderstanding, self-pity, loss of confidence, and withdrawal from social contacts which have become difficult and occasionally embarrassing; and, on the part of those around him, a withdrawal of social contacts because of their difficulty, his "stupidity", and his attitude of suspicion and "blaming other people for his own faults". A pattern of increasing loneliness.

There are several tasks we have to face: to reconcile him to the true picture of his disability; to help him to realise what his capabilities now are; and to help him to use those capabilities to the utmost so that he can again assume an active social life. For this we have two main resources at our disposal: hearing aids and lip-reading.

Limitations of Hearing Aids

Hearing aids can be a very great help, but all hearing aids suffer from limitations which are not generally recognised and which prevent them from being a complete answer on their own.

(*a*) An aid only increases the strength of the signal reaching the cochlea. If the cochlea is affected (and in the majority of cases of deafness in later life it is) *no increase* of signal strength to the affected area will elicit any response. And by amplifying the low-pitched sounds (which he may still hear tolerably well) to any great extent it will render speech *less* intelligible in a great many cases. (Shouting also does precisely this: it increases the loudness of the voiced components so that they tend to smother the unvoiced components, the vital consonant sounds, whose loudness is scarcely increased at all. It is much better to speak loudly at very close range.) Further, in some cases of perceptive deafness there is a fringe area of sounds, bordering on the deaf area, in which a very small increase in the loudness of a sound will render it acutely painful. In these cases great care must be taken in using an aid—if it can be tolerated at all.

(*b*) An aid amplifies all sounds reaching the microphone, including noise and echoes. Because of his deafness the new hearing-aid-user has become unaccustomed to sorting speech out of the welter of other sounds, to mentally suppressing unwanted sound, and the reintroduction of the world of noise is distracting and distressing and he has to relearn the trick of concentrating on speech.

(*c*) In the period before he starts using a hearing aid a person losing his hearing gradually becomes accustomed to an imperfect pattern of speech and has unconsciously come to accept this as normal. Any aid, no matter how good, will present a pattern differing from this normal and the common reaction is to accuse the aid of distorting. The user of a hearing aid has to adjust himself to an *altered* world of sound; his habitual interpretation of sounds has to be revised, and this readjustment may be a long process and a very difficult process for the elderly.

Lip-reading is the method of gathering the speaker's meaning by observing the movements of his lips and face. It has a great many limitations:

(*a*) A number of the sounds of speech have no clearly visible movement (e.g. *h, j, ng*); others have the same movement (e.g. *p, b, m*). But since the usual unit of speech is the phrase, these unseen or doubtful movements form only minor gaps in a comparatively long pattern, so this defect is much less serious than might at first appear.

(*b*) Since lipreading depends on vision, lighting conditions and the angle of the speaker's face are important. Unlike a hearing aid, it is useless in the dark and "round corners".

(*c*) The peculiarities and mannerisms of the speaker play a big part: stiff lips, unexpressive face, the angle at which he holds his head, excessive head and/or body movement, can all render lip-reading difficult or virtually impossible.

(*d*) Lip-reading is difficult when there are several people in the conversation. There may be no clue as to who is going to speak next, it may not be possible to keep everyone within the range of vision, so the first words of the new speaker may be missed (as may be most of the remarks and interruptions which can come from any angle without warning) and the thread of the conversation hopelessly lost. Again, the deaf person is liable to speak without realising that someone else is already speaking—causing "rudeness", confusion and embarrassment. On the other hand, lip-reading has a number of advantages.

1. The consonant sounds, which play the major part in making speech intelligible, are the sounds which are the most readily visible; and these are the very sounds which cannot be brought back by a hearing aid in cases of perceptive deafness.
2. Lip-reading does not suffer from the danger of fading battery or failure of components.
3. The more severe the deafness, the less a hearing aid can help, and the more useful lip-reading becomes.

The Battle of Readjustment

Neither the hearing aid nor lip-reading provides a really satisfactory answer on its own; the best results are obtained when the use of both is combined. It cannot be too strongly stressed that merely to provide a deaf person with a hearing aid and leave it at that is a grossly inadequate method of dealing with the problem. It leaves the sufferer to fight the (generally unexpected) battle of readjustment alone, and all too often with his exaggerated expectations disappointed.

The basic aim of all rehabilitation work with elderly people becoming deaf is to enable them to regain an active social life (in the broadest sense). One of the great advantages of lip-reading is that instruction in lip-reading is almost invariably given in groups and this offers the deaf person an opportunity to re-enter social life through a small group composed of people who can offer him sympathetic understanding because they too are meeting and overcoming problems similar to his. It does not

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Never a Dull Moment

by IDA M. FOULDES,
County Home Help Organiser, East Sussex

ELEVEN years ago when I was appointed to be the county home help organiser, the service was in its infancy and its growth could not be visualised. However, by patient day-to-day work by all concerned it gradually developed and has more than proved its worth and I now look back over the years and wonder how this tremendous growth has been achieved.

In June 1948 the county council appointed the W.V.S. as their agent to organise the home help service within the county and as this arrangement still exists my first duty is to co-ordinate the two services, the one statutory and the other voluntary.

In order to bring this activity in line with other W.V.S. work, the county is divided into urban and rural districts and a W.V.S. member appointed as home help specialist in each area. The rural areas, being too large for one voluntary worker to cope with, are divided into three or four districts so that altogether thirty-two W.V.S. members organise the daily service over the county.

Theirs is no easy task; the telephone rings at all hours of the day and night with requests for help and sudden changes of requirements. They must be tolerant, patient, and understanding and be ready to take quick action. Keeping in constant touch with each area specialist is perhaps the most important part of my work, as it is vital for her to feel that she is not working alone. The sense of isolation can so easily grow, especially when working in the remote rural districts.

I must always bear in mind the place of the home help service within the health team, and endeavour to keep in close touch and harmony with the other services and organisations of the community and to see that these good relations exist between each area specialist and the representatives of the different organisations in her area.

The infinite variety makes it extremely difficult to give a clear picture of the day-to-day work, for no matter what plans are made, one telephone call may shatter the whole programme and I will find myself in the car on the way to some part of the county where some emergency has arisen and a personal visit seems to be the only way of dealing with it.

The county home help office is of course the nerve centre of the service. The first job in the morning is the post, which might contain anything from the usual routine forms completed by the householders, together with explanatory letters sometimes taking three or four pages, to a terse note advising me that some unknown woman has produced a baby and will I please send the woman who is "to do" for her. This last note sets the real problem. The postmark is hopefully scrutinised and if with success the appropriate W.V.S. specialist is telephoned and it is then her job to deal with the matter.

If, however, the postmark is illegible, then the card index of booked maternity cases is searched and any baby due on or about this date is noted and the area specialists in the districts concerned are asked to make urgent visits to the likely houses until the right one is found and the home help already booked, and probably waiting, is sent. All of which takes some time!

The Human Element

Then that most human document, a letter from an area specialist asking for advice on a particular case, or more often than not just a note advising me that she has taken on a particular case, which often means that once again her heart has ruled her head and she has undertaken yet another problem. Replying to a letter of this kind usually means a telephone call, a reassuring chat and an appointment made to visit the case with her.

Often on arriving at the office my telephone is ringing and to my mind immediately flashes the question "Whose baby has arrived early?" Then I hear a man's voice saying "My wife had her baby last night" and by the time I've noted his name and address (he is always surprised that I haven't guessed it) I am already wondering which resident home help is free or which one can be safely removed from a case nearing completion. Here I would explain that the resident home help is an official superannuated county council employee and is paid at a weekly rate, and therefore differs from her sister the daily home help who is a casual worker and paid by the hour. There are approximately 550 of these casual workers in the county. The only casual thing about them is their title, for their work and the interest they take in it is anything but casual.

One of my main duties is to visit the various W.V.S. offices, especially on the days when the home helps come in to sign their timesheets and to receive new ones and a programme of work for the next fortnight. This is also the opportunity for me to discuss some of the cases with the area specialist and to chat with some of the home helps. I try to take a personal interest in their welfare but as there are so many this side of the work must be left to a large extent to the W.V.S. member who knows them more intimately than I can ever hope to do.

The recruiting of the casual daily help is, of course, the responsibility of the local area specialist. In the case of a resident home help, however, it is essential for her to be interviewed by me, together with the assistant county

medical officer, and her work is planned and supervised from my office.

While I am at these centres some of the health visitors take the opportunity to call and discuss with me any cases they are anxious about and where the provision of the right type of home help at the right time might prevent the breaking up of a home or prevent the family from developing into a problem.

It is not so easy to visit the home help specialists in the rural areas who work from their homes, but many of them come in to my office from time to time bringing their problems with them, and periodically I call a meeting when they all come to discuss their difficulties and air their opinions, which they do in no uncertain fashion. We look forward to these occasions.

My deputy and I attend the co-ordination committees sponsored by the children's department. These meet once a month in four different parts of the county and deal with the problem families in their respective areas. There is an ever-increasing demand for the use of home helps in some of these cases, and as very careful consideration must be given to the type of home help sent into such homes either myself or my deputy supervise these cases personally. The home help who is chosen for this type of case must be discreet, warm-hearted, and possess both patience and tact. She requires encouragement from time to time because naturally she is liable to become disheartened when after several weeks of really hard work there is no apparent improvement in the situation. In the majority of cases, however, she does eventually see some reward for her labours and feels that it has all been well worth while.

Contacts with Health Department

Being directly responsible to the county medical officer I must keep him informed of the progress of the work and discuss with him any problem which I feel unable to deal with alone. As he is a very busy man I take to him only the most pressing problems which cannot be dealt with by other members of his staff or his personal assistant. A quarterly report is submitted to him and is included in his report to the nursing services and care sub-committee of the health and housing committee of the county council.

Appeals for help come from all sources: doctors, nurses, hospital almoners, children's officers, old people's welfare committees, mental health visitors, National Assistance Board, the blind and cripples' associations, and others. Requests for daily help are usually made direct to the local area specialist who must visit to investigate the need as soon as possible. Application for resident help, usually for maternity cases, come direct to my office when either my deputy or myself visits to decide whether or not the home is a suitable one for a resident home help.

I must now turn to the less interesting but vital side of the work which is carried out in my office. All the home helps' timesheets are sent to me by the area specialist, together with lists of new and completed cases and her comments on some of them, especially where it has been necessary for her to increase the hours originally allotted to the case. These timesheets must be checked and certified correct by myself or my deputy before being sent to the county treasurer for payment by cheque. A card index of all cases is kept and the hours worked each week are recorded on each case card.

CONGRESS DELEGATES

Miss Joan Gray leaving London for Australia, where she attended the I.C.N. Congress and visited nursing associations. With her is Miss Lucy Jones

The home help service being a permissive service is restricted financially and expenditure must be carefully watched. This means that the hours of labour used each week must be controlled and therefore each area specialist is allowed a certain number of hours based on the population in her area.

To sum up the work of a county home help organiser:

First: To train, guide and support home help specialists in their work;

Second: To engage and plan the work of the resident helps;

Third: To check the timesheets and to deal with any complaint with regard to the service, however small;

Fourth: To co-ordinate the service with the other departments and organisations in the county, and prepare the quarterly reports on the progress of the work for the information of the county medical officer of health.

In conclusion, I would like to think that this article has succeeded in persuading all those people who have the impression that mine must be a very dull and dreary job indeed, how very wrong they are. Exacting it may be at times, but it also has infinite variety as you can see, each day bringing its full quota of very human stories and incidents, some tragic and some gay, with the result that there is never a dull moment—there just isn't the time!

The health visitor teaching this subject must first and foremost have a desire to help the teenager, to understand her changing moods, and to like teaching

Mothercraft Teaching in Schools

by **ANNE M. LEE**, S.R.N., S.C.M., Q.N. and H.V. certs.
Health Education Officer, Leeds Education Authority

MOTHERCRAFT teaching—what does this bring to our minds? Demonstration bathing, the right type of baby clothing and the nutritional needs of children, food values, breast- and bottle-feeding, and cleaning bottles and teats?

These and many other factors are important, but just how valuable is this teaching? Detailed instruction will be given in many or all of the above-mentioned aspects of child care, by the midwife, district nurse and health visitor, later on when the mother or mother-to-be comes under her care. By the time she needs this information the pattern of child care may have changed yet again. Therefore when dealing with this subject one must not be too dogmatic; also there can be a tendency to expect the schoolgirl to accept and understand too much that is not related to her particular needs at the time.

Many girls are aware of cases of child neglect and possibly of cruelty, depending of course on their home environment and surroundings. Right knowledge may therefore be a valuable contribution towards the prevention of so much unhappiness in the lives of young children. Many girls of school age also do periods of baby sitting, or help to look after their younger brothers and sisters. Much can be done here in teaching them how to prevent accidents, both at home and on the roads.

Bearing this in mind, therefore, the aim of mothercraft teaching should be:

(*a*) To promote in the girl an intelligent interest in the growth of children and their physical, mental and emotional needs;

(*b*) To attempt to create a gradual awareness in the girl of her future responsibilities;

(*c*) To help her to develop a sense of dignity and poise and a constructive attitude to her personal relationships both inside and outside the home.

All this must be related to the opportunities given to us to impart the knowledge. These will vary considerably according to: the time allowed; the numbers in the class, and the age-range; classroom facilities; teaching materials, books, flannel graphs and other visual aids; the co-operation of the teaching staff.

Analysing the aim will make us realise that the subject mothercraft covers the whole range of health education; namely, to help the girl towards successful maturity of body, mind and spirit.

This can be done in many ways, for example the care of herself, personal hygiene; the understanding of the physical, mental and emotional changes of adolescence; her attitude towards others, and discussing the approach of the change from school to work; and her future as a probable home-maker and mother.

It is impossible to define in a short article the range of work that should or can be covered by any health visitor attempting this work. Much of the content will be taught in the housecraft departments (personal hygiene and food values) and in the science department (human anatomy and physiology). Even so, with the health visitor's nursing knowledge much can be done that would not otherwise be dealt with, e.g. in dispelling fears and old wives' tales.

The planning of a syllabus and work schemes will of course only be done with the co-operation and support of the head teacher. Where a health visitor is employed as a full-time teacher of health education, the scheme can cover the full range of health subjects, from the first to the senior forms.

All such work depends on the needs of that particular school, and the types of homes from which the girls come. Emphasis may be needed sometimes on the personal hygiene aspect or on the moral side.

The health visitor teaching this subject must first and foremost have a desire to help the teenager, to understand to some degree her changing moods, and to like teaching. This is most important, or she may feel overwhelmed if faced with a large class of adolescents. It is necessary to be able to maintain class discipline, and yet to be able to produce an atmosphere in which the girl feels free to ask appropriate questions and has the desire to learn. It is always better to teach mothercraft informally where possible.

Health education should have great value in helping to prevent ill-health, both mental and physical, and to produce a mature citizen of the future, and thus a more stable home-maker and mother.

Deafness in Later Life *continued from page 29*

matter whether it is a class in lip-reading run by the local authority or one run by, or in conjunction with, a social club for the hard of hearing (though the latter is to be preferred because the clubs generally organise a number of other social activities for their members in addition to the lip-reading instruction). So learning to lip-read can be of indirect assistance too.

Above all, the person who is losing, or has lost, his hearing needs sympathetic understanding, guidance, and encouragement from as many as possible of those who come into contact with him if he is to break through the twin barriers of handicap and loneliness and re-enter the happy social existence that is the need and the right of all human beings.

THE SECRET GARDEN

Photograph by courtesy of Birmingham Post and Mail

Arden Croft, the "secret" garden, is hidden away barely a mile from the city centre of Birmingham. The lake shown here is fed by natural springs. The seven acres of gardens include a bird sanctuary and a wild garden, and are believed to be on the site of a centuries-old priory.

Arden Croft, 6 Sir Harry's Road, Edgbaston, Birmingham 15, will be open to the public under The National Gardens Scheme on Whit Sunday, 21st May, from 2 to 7 p.m.

The Gardens of England and Wales Open to the Public lists all the gardens which may be visited under The National Gardens Scheme. It is on sale at leading bookstalls, price 2s., and may be obtained from 57 Lower Belgrave Street, London, S.W.1, price 2s. 6d. including postage.

Stroke Rehabilitation

THE Chest and Heart Association is organising a conference of Stroke Rehabilitation on Thursday, 22nd June, from 10 a.m. to 5 p.m., in the Livery Hall, Guildhall, London, E.C.2.

The conference is open to everyone concerned in the care of "stroke" patients—doctors, nurses, physiotherapists, social workers, and the patient's family.

Detailed programmes are freely available and will be sent to anyone on request. Programmes, and tickets price £2. 2*s*. including a buffet lunch, may be obtained from: The Chest and Heart Association, Tavistock House North, Tavistock Square, London, W.C.1.

QUEEN MOTHER TO PRESENT LONG SERVICE BADGES

QUEEN Elizabeth The Queen Mother will present twenty-one years' long service badges to Queen's nurses on 14th November. The ceremony will take place in the State Rooms of St. James's Palace.

The Queen Mother last presented long service badges in 1953, the year in which she became patron of the Queen's Institute.

Over a hundred nurses qualify for the badge this year, and it is expected that the majority will manage to attend the ceremony. Those eligible will receive full details later.

A county service which relies on co-operation between the hospital and domiciliary services

Pembrokeshire Midwifery Services

by **JEAN M. YOUNG**, S.R.N., S.C.M., Q.N. and H.V. certs.

County Nursing Officer, Pembrokeshire County Council

MIDWIVES are well aware of the difficulties of providing a maternity service to meet the needs of mothers during the ante-natal period, labour and puerperium. In this day and age, when women are needed in many professions, any scheme must have regard to the woman power available. A maternity service must be planned to make the best use of the obstetricians, general practitioners and midwives available, both in hospital and on the district.

In this area, which has a birth-rate of 17.45 per 1000 of the population, it became necessary some three years ago to take positive steps to make proper use of domiciliary as well as hospital services. We welcomed the recommendation of the Welsh Board of Health that hospital beds should be reserved for primigravidae and gravidae IV and upwards, obstetric abnormalities and those with very special home difficulties.

In this county, maternity beds in general practitioner units are allocated mainly by the county medical officer of health, who delegates this responsibility to the county nursing officer, who is also the non-medical supervisor of midwives. Requests for maternity hospital beds are made mainly by general practitioners. Beds are reserved only for mothers in the categories for which hospital confinement is recommended.

There is a small unit for major abnormalities, in the charge of a consultant obstetrician who accepts overall responsibility for the other hospitals. In the event of an abnormality occurring on the district and requiring hospitalisation, it is usually possible for the patient to be admitted to the general practitioner unit if her doctor wishes. He can then continue to provide care himself. The patient is then discharged home as soon as possible and is cared for by her own midwife. Otherwise, very early discharge from hospital is the exception, not the rule. Maternity hospital discharges before the tenth day are notified to the county nursing officer who arranges for a midwife to call the next day.

Regular Classes

An ante-natal clinic is held at each hospital weekly, and there is also a relaxation and mothercraft class at the general practitioner unit, which is attended by the matron, the physiotherapist and the health visitor. We hope that patients booked for home delivery may be able to attend this class later on, and when our new building is completed early in 1962, we anticipate a class there.

This scheme met with considerable opposition at first, but is now working well, and once the patients have accepted the idea of home delivery for their second and third children at least, we seldom have any difficulty. A number of first babies are born at home, but district nurse midwives are instructed to offer hospital confinement to grandmultiparae, and a bed is always found if the patient can be persuaded to accept it.

Daily Communication

This scheme could not operate without the goodwill of the county obstetrician, the general practitioners, the matrons and maternity sisters at the hospitals and the midwives on the district. We all know each other, and the county nursing officer is in communication with some members of the team daily. We are not complacent—we are deeply conscious of the need for constant review of our service, but we are convinced that co-operation between the hospital and the district services is essential if we are to give the best service to our mothers.

The second prize winning essay in the B.M.A's 1960 competition for state registered nurses working outside hospital

The Nursing of Old People

by **MARY R. DICKINSON,** S.R.N., S.C.M., Q.N. and H.V. certs.

"*SUFFERING . . . in the case of another we should regard as wholly evil, should endeavour to experience the sum total of it by a compassionate sympathy in our own person, and then, made active by imagination, struggle with all our power to relieve him of it.*"*

The old endure many kinds of suffering, and it is not only their physical suffering against which we must struggle with all our power. An old patient is not simply a case to be nursed. He may present a wide variety of problems which are not strictly nursing problems at all. We must remember too the problem of old age as a whole. This is a national problem with which we are all vitally concerned. There has been a fourfold increase in the old-age population in twenty years. There were five million old people in 1947; there will be seven million in 1977. Of these millions very many present problems, especially when they become ill, and as nurses it is the individual problems with which we are concerned. At last a real interest is being taken in old age in all its aspects, but the science of geriatrics is still in its infancy, and we cannot measure what is normal at seventy as we do with the different landmarks of childhood, so we have no real standards of comparison for old people's physical and mental capacities, but we do know their common needs.

When trying to help an old patient there are three chief things to bear in mind. First we must preserve his self-respect by allowing the fullest possible measure of independence for the longest possible time. It may be much easier to dò things ourselves, much less worrying to watch over him if he is allowed up than to risk a fall, but every time we give in to the easy way we are destroying a little more of the person we are trying to help, making him a little more detached from life, a little more of a burden in his own estimation.

Secondly, we must recognise and try to alleviate the suffering caused by loneliness. This is the kind of suffering of which we must "endeavour to experience the sum total". It is the greatest enemy, the one we must never forget. There are many kinds of loneliness, but the most common kind is preventable by the simple word or act of genuine kindness. Very often people just don't bother. Very often we do not bother ourselves, and dismiss it, if we think about it at all, as pressure of work. We must bother. And we must get other people to bother too.

Thirdly, we must not shirk our responsibility for nursing people in their own homes if this is possible at all. Home for old people is their chief source of happiness. The china dog, the text on the bedroom wall, the faded sepia wedding photograph, these are "the things which belong unto their peace", which make their memories real to them. We cannot lightly rob them of these.

There are, of course, old people who simply cannot be nursed at home. If the presence of an old chronic patient is genuinely militating against the happiness of a young family, or causing severe marital strain, then the claims of the family must take first place. Also we still come across a few cases which are covered by Section 47 of the National Assistance Act, where the old person is in such a condition that removal to a home or hospital becomes imperative. Such a situation should never be allowed to occur. As the late Dr. Dennis Geffen, writing of the St. Pancras scheme for nursing old people at home pointed out, there should be no Section 47 cases. They represent our failures in this field.

Looking Below the Surface

When we are called in to nurse an old patient, perhaps only for something quite simple, that is our opportunity to find out all we can about him. Is he suffering "in mind, body or estate"? Is he worried about money? Does he have supplementary pension? Does he need another blanket on his bed? Is it so long since his spectacles were changed that he cannot read? Could he be persuaded to have a hearing aid? All these things and many more can be obtained for him. It is not always realised how wide are the powers of the National Assistance Board, and how good and patient they are in carrying them out. They will give a sympathetic hearing to what may seem very strange requests. The Red Cross and the Women's Voluntary Services are likewise very helpful, and if we are still worried there is the National Old People's Welfare Committee, a voluntary body set up in 1940 to co-ordinate the services for the welfare of the aged.

In some districts we can call upon visiting chiropodists and physiotherapists, or the excellent Meals on Wheels Service. It would be grand if we were able to introduce this in the country with the help of the Women's Institutes and Women's Voluntary Service.

The chief stumbling blocks are often, of course, the old people themselves, with their dislike of innovation. It takes time and patience to get them to accept any of these things, but it is at least worth trying.

Most important of all if we are to keep old people at home is the home help service. Unfortunately it is always one of the biggest problems to find suitable people for this sometimes rather thankless task. We should like to see a nation-wide drive to recruit and train home helps in

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* Victor Golancz in "My Dear Timothy."

The History of Queen's Uniform and Badges

BY 1890 it had become clear that some sort of uniform for Queen's nurses would have to be devised and that bodies affiliated to the Queen Victoria's Jubilee Institute for Nurses should be advised and where possible persuaded to adopt this uniform.

Later that year, the council assembled various patterns of complete nursing kit for submission to Queen Victoria, who expressed a strong wish for uniformity in caps. Tradition records that she had even more positive ideas and that when confronted with a pile of caps she selected one and bending its brim into a Marie Stuart peak, said: "I would like this one if it were altered so". And altered it was —to become in due course the pattern of headdress worn by Queen's nurses for many subsequent years.

In February 1892, through a uniform sub-committee, dress material of hard-wearing cotton in light and dark blue stripes (the Jubilee colours) was approved by Her Majesty.

In 1893 the council finally recommended, and the Queen approved, an Institute uniform for the qualified and enrolled nurse of all affiliated bodies which might wish to adopt it.

It was comprised of a cap and bonnet of the "type selected". A dress of the "sealed pattern" with holland sleeves and apron, and a plain cloak of dark blue material. It was hoped that all enrolled Queen's nurses would wear this uniform, but whether they did or not, there were certain distinguishing objects which all Queen's nurses on duty were required to wear: these were a brassard and badge. The brassard combined the Queen's monogram V.R.I. which was to be worn on the left arm of all Queen's nurses while the badge was to be worn as a pendant on a ribbon or cord round the neck.

The badge was designed by Mrs. William Rathbone and the council ordered it to be struck in three metals, gold, silver and bronze. This badge consisted of an openwork metal reproduction of the royal monogram, surmounted by a crown with a surrounding band of the same metal inscribed "Queen Victoria's Jubilee Institute for Nurses 1887". The gold badge was to be awarded, with the Queen's permission, for distinguished service to the Institute. The silver badge was to be worn by nursing superintendents, and the bronze badge by the rank and file. The gold and silver badge was to be suspended on light and dark blue striped ribbon and the bronze badge on an entwined light and dark blue cord.

The badge has survived all changes of fashion as the distinguishing mark of the Queen's Institute nurse. In the year of its inception it indicated that the wearer had satisfied the training requirements adopted by the council of the Institute. Then the Queen's nurse was required to have had one year's training in a recognised school attached to a general hospital plus six months' district nursing. For nurses not employed in large towns, three months' maternity training was also required.

On completion of her training, a Queen's nurse was required to work as a district nurse for at least eighteen months in whatever situation the Institute might decide but in order to be admitted to the Queen's Roll as a Queen's nurse, she was required to work in the service of an affiliated association subject to the Institute's inspection.

In 1921 the brassard was abolished and during the 'twenties the storm cap and coat took the place of the cloak and bonnet. By 1927 a general change of uniform received official blessing and the standard dress became the coat frock loosely belted, an overcoat with sleeves and pockets, and hats of straw or felt of approved design, or alternatively, outdoor storm caps.

The uniform remained almost unchanged until after the second world war when it was redesigned in 1946, and included the introduction of epaulettes and flashes.

Photograph by courtesy of Keystone Press Agency Ltd.

The early uniform which survived until the nineteen-twenties. The skirt started at ankle length and gradually rose

This article is adapted from chapter six of *A Hundred Years of District Nursing* by Mary Stocks.

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awarding only one size of badge, in silver for administrators and in bronze for nurses. These badges are made with a loop and a pin, so that they may be worn on a ribbon or cord as at present, or as a brooch at the neck or on the right lapel. Male nurses will continue to wear the small bronze badge with a stud fitting.

The Queen's badge will no longer be regarded as a badge of office, to be returned when that office is given up. This means that all Queen's trained nurses may wear the badge, irrespective of where they are working. All Queen's nurses including "ex-Queen's" should write *now* to the Institute giving name, roll number and address, to which the new badge engraved with her roll number will be sent after 1st June. From 1st June the new badges will be issued to all nurses passing the Institute's district nurses' examination.

In future, a nurse will be required to relinquish this badge only on account of unprofessional conduct.

THE 1961 LOOK IN UNIFORM

The comfortable, straight coat, also made with raglan sleeves

WITH spring in the air, and summer clothes and holiday wear in the shops, the mind of many a woman is turning to her wardrobe. She looks hopefully at favourite garments—are they fit to wear another season? And despairingly at the less-liked and therefore less-worn garments—won't they ever wear out? How can she alter the appearance of those she is tired of ? However, when she comes to her uniform, she passes it by quickly—nothing she can do about that.

But is there? This year the answer is yes. After carefully considering many criticisms and suggestions regarding Queen's nurses uniform, and after inquiries made of superintendents and nurses all over the country, the uniform and accessories have been altered in various ways in order to bring them up to date with regard to practical requirements and to fashion.

The most striking change is the abolition of flashes and epaulettes which were introduced in 1946. They should not be worn after the end of this year, and any which wear out before then should not be replaced.

The newly-designed dress is a princess-style with a concealed front-fastening to below hip level (no zips, side plackets, or waist seams to rise each time the dress is washed). The short sleeves are piped with white, and the edge-stitched pockets on the bodice give a pleasant, slanting line as well as taking a pen and watch; a small tab with a button for the square-bib apron tucks inside each pocket when not in use. There is another pocket in the skirt seam. Two necklines are available: a high neck or a V, both with a detachable white collar.

This single-breasted suit has a softer line than its predecessor, particularly in the lapels

This dress is made in delphinium blue special finish cotton or a suitable mixture, for nurses; and in various navy blue materials for administrators; all materials must have satisfactory anti-static and washing properties. Administrators may also wear dresses to the existing pattern with a yoke front and back.

The jacket of the double-breasted suit for administrators and for nurses working as full-time health visitors is hardly altered. There is, however, a single-breasted version which has softer, more feminine lapels and slanting pockets. The skirts are considerably smarter than before. There is a simple straight skirt, with a slit centre back; and for those who like more freedom, a skirt which appears straight from the front but has a box pleat at the back. For health visitors who cycle, there is a flared skirt cut in six panels.

Those who prefer to wear a loose coat over a suit will like the new straight coat which comes with raglan or inset sleeves. The collar can be fastened up to the neck.

The four familiar types of hat remain, but are joined by a special light-weight summer hat. This is made in the riding style only, and is particularly attractive in water-repellent synthetic straw. It also comes in proofed poplin; both are navy blue.

The new-style dress may also be worn without a belt. Small inset shows the V-neck

Two existing items of uniform are worth particular mention: First, how many people know that a delphinium blue blouse may be worn with the suit, in addition to white or navy blue?

Secondly, black stockings. Although a lot of people have asked if light stockings could be approved, ballots taken on several occasions reveal that the majority are in favour of retaining black stockings. This is not surprising when one remembers that black nylon is the most slimming stocking there is, and therefore the most becoming to the majority. And since fairly dark and black nylons are the fashion for ordinary wear these days, what more could one ask?

The Badge

Owing to the large number of administrative categories which now exist, there are many anomalies in the wearing of large and small silver badges.

The Queen's Institute has therefore decided to revert to the original practice of

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every corner of the country. It is a truly worthwhile job, and should receive the recognition and status it deserves. With unemployment rising, now is the time to make a determined effort to recruit them. Neighbours can be very helpful, but not every patient is blessed with good neighbours, and the burden and responsibility on a visiting neighbour can often be far too heavy.

So much for our old patient's estate. What of his physical needs? As district nurses the illnesses we most often come across among the aged are strokes, chest and heart conditions, arthritis and all degrees of rheumatism, fractures, senility, and a few other conditions. The painful disease of shingles, for instance, is quite common among old people.

Real Nursing is Still Needed

We sometimes complain that there is little real nursing nowadays, and that all we do is to go round giving injections; but all these conditions require real nursing care, and the use of all our knowledge and ingenuity. No one can say that there is no art in nursing a haemiplegia patient in a feather bed. All old patients need constant and scrupulous attention to mouth and pressure points, feeding and changing of position in bed. The bowels must be watched, and here the new suppositories and disposable enemas are a great assistance.

The difficulty is to fit in the treatment in the twice-daily visits which are normally the most that can be managed to any single patient. The visit must be very well planned to try to fit everything in without unduly tiring the patient, and to try to teach the relatives to carry on treatment in our absence. Here we must bear in mind that details which seem to us quite obvious, such as covering hot water bottles well, may not occur to someone who has never had anything to do with sickness.

Nursing is rendered more difficult when the breathing is very distressed, and here it may be necessary to do only what is absolutely vital. In heart cases we need to recognise and allow for the extreme irritability often caused by the condition.

In arthritis and rheumatic conditions and the milder haemiplegias, our time is best spent encouraging the patient to do things for himself, and in trying to suggest ways and means, and perhaps introducing gadgets to enable him to be more independent. There are many such gadgets now obtainable, or easily made at home. In diabetes, education of the patient and relatives is of first importance. Many families have no idea of food values.

Many of our patients are cancer cases sent home to die, and here the family needs all possible help and support, not only to nurse the patient, but to overcome the fear and horror of the disease, and sometimes to reassure them that it is not contagious. These cases are often very distressing and if they upset us, what must it be like for the relatives? We need to remember how much more difficult it is to nurse one's own people, and the strain of witnessing suffering all day and every day, and sometimes hardly ever getting away from it. We should try to safeguard their health also. They need help, too, in practical ways. For instance, the laundry from an incontinent patient may be undertaken by the local hospital.

We set out to teach the families, but very often they teach us. Anyone in constant attendance on a sick person, who really cares, will find out all sorts of little dodges suited to that particular patient, and which we may be able to pass on to others. I have been amazed and humbled on the district to see the ceaseless devotion of different members of the family, men as well as women, nursing the old and chronic sick.

"Mind, body and estate." The ills and sufferings of old people, are, like our own, often aggravated or even caused by the mind itself. This is too vast a subject to enter into fully, but here are two examples.

First there are the old people who feel rejected and unwanted; who begin to reject themselves, and become the victims of depression. Perhaps they have outlived their families, or their children have gone away and seldom visit them. This sense of rejection may show itself in a variety of ways. If people do visit them they may alienate them completely. When they have been alone for a long time they may become quite childish and tearful, and resort to senile behaviour.

The best help we can give to these old people is to listen to them, to try to provide some sort of substitute for the people that have gone out of their lives. We should pay them little attentions, and try to give them something to go on living for. If we can get others to visit we should. There are many voluntary organisations everywhere who undertake visiting, from Toc H to the Girl Guides. Incidentally, tradespeople in the country are often excellent social workers, whose visits brighten many old people's lives, and provide some contact with the outside world.

A totally different type for whom old age is very hard, are the very active people who love life and every moment of it. There are still so many things they want to do, and enjoyments they must forego, and often it is a bitter disappointment when they are eventually forced to give up things which they have been used to doing. These people are apt to become casualties through attempting too much. These are the kind of accidents which we must try to prevent, perhaps by providing some distraction in the home such as a wireless, or putting them in touch with an old people's club if there is one near, where they will be able to have a little fun without being overtaxed.

We must beware of lumping all old people together. They form a complete cross-section of the community. One of the most noticeable and interesting things about them is their individuality, which seems to become intensified and crystallised by old age, perhaps because they have less ability or less opportunity to hide their true selves, or because living in some degree in isolation they are thrown back upon themselves.

The chronic worriers will worry more than ever. The mean streak that was well hidden may be pathetically obvious now. They may have curious little habits designed as spiritual props and comforts. They may have lost con-

tact with reality and retreated into themselves. Most really old people do have times when they behave very much like children, with the same unreasoning attitudes and prejudices. Like children they can be side-tracked or cajoled or flattered, and their response can be unexpected and delightful. Almost all old people whom we term "senile" will improve with more interest and attention.

But if they can be childish they can also be very wise. There is so much that we can learn from them. They can give us the cumulative wisdom of a long life, and make the past come alive for us. They preserve our folklore, and the old ways of life, the independent ways of those grand people, the Victorians. They can help us with our problems too. Because they are a little apart they have a long view. If the technical satisfaction of seeing an old patient comfortable is one reward of our work, another is the pleasure of talking to them. Our relationship is not at all one-sided.

There are old people whom we meet who present opportunities for rehabilitation, and others who present opportunities for prevention. Lastly there are the old people who are dying.

We have been told not to identify ourselves with our patients, but within limits nursing is meaningless unless we do. If we choose to nurse then there are no half measures, and no legitimate excuses. We must be "made active by imagination" to feel what it is really like to be completely helpless, completely dependent on a stranger for the most intimate details. We must make them feel that this just doesn't matter, really convince them that we think nothing of it, and nor should they.

Many of these patients know that they are dying, and suffer from terrible loneliness and the incommunicable fear of death. This is something that most of us can only imagine; all we can do is to struggle to get our sympathy through to them, make them feel that we are with them, each in his or her own way. We do not know how this is best done. We can only try and go on trying.

I think that the perfect words to help and encourage us are those by Robert Louis Stevenson, himself a dying man. "Gentleness and cheerfulness, these are the true moralities. They are the perfect virtues."

The true moralities and the perfect virtues. How often have we seen them demonstrated in our old patients. How often it is they themselves, their courage, their gentleness and cheerfulness that enable us to go on trying.

Suffering for them, we should regard as wholly evil; we should struggle with all our power to relieve them of it.

Do Your Patients Knit?

W.V.S. needs thousands of knitted squares for making into blankets and shawls and a few days ago one of our members wrote:

"The district nurse who came to see my mother this week asked about the square she was knitting, and said what a wonderful idea it was. She was sure lots of the old ladies and other patients that the district nurses go to would love to have something like that to do, something that they don't have to concentrate on or pay for themselves, as although many of them love knitting they have not any spare cash to knit for themselves."

This letter made W.V.S. realise that up and down the country there must be people lying in bed who would like to knit or crochet these brightly coloured squares, six-inch ones for blankets and four-inch ones for babies' shawls and cot covers.

W.V.S. in towns and villages appeal for odds and ends of wool and outside many offices including W.V.S. Headquarters at 41 Tothill Street, may be seen a collecting box asking for unwanted wool. Into these boxes are dropped whole skeins, and ounce balls as well as half ounces and tiny scraps of wool, and even the piece of knitting started and never finished.

Nurses who would like wool for their patients are asked to get in touch with the local W.V.S.; other nurses may be able to help by collecting wool from patients and friends.

At the moment W.V.S. are collecting 20,000 layettes to send to refugee babies in the Middle East and each layette has in it one shawl. The blankets are given to needy people in this country, and also go to refugees in various parts of the world.

Knitting these squares may bring great happiness to many sick people if they realise how greatly the blankets and shawls are needed; whilst at the same time warmth and comfort will be brought to the very old and very young and to the sick and needy in their own homes and in refugee camps when the bright warm blankets are distributed.

Plymouth Public Secondary School girls handing over to W.V.S. organiser sixty blankets which they made for World Refugee Year

Photograph by courtesy of The Western Morning News

A district nurse retires from the small island of Fair Isle and ventures to the New World

Adventure Begins at Sixty

IT is not given to everyone to spend the last day before retirement making a bouquet which was to be given to the Queen, and later that same day to be presented to Her Majesty oneself. But such was the wonderful experience I had on my last day on Fair Isle.

The weather was unfavourable because of wind and tide but after a day of speculation on the chances of the visit taking place, *Britannia* finally arrived about 9 p.m. The royal barge then brought the Queen and the Duke of Edinburgh accompanied by Princess Alexandra and Prince Michael to the south pier. When they stepped ashore we were all conscious of the high honour being conferred on us. The Queen was dressed in a warm cream-coloured coat and hat and seemed relaxed and happy. The harbour was gaily decorated and as the barge was approaching the island, a twenty-one shot-gun salute was fired which greatly amused the royal party.

After various presentations had been made, the Queen and her party boarded a lorry which took them to a croft where they had tea seated by the peat-fire. Then they went to the village hall where the knitters were waiting with their beautiful Fair Isle garments; several articles were presented to the royal family. The visit was informal and was much enjoyed and appreciated by everyone.

The Twilight Walk

Instead of returning to the harbour by lorry the Queen and Prince Philip decided to walk and led the way in the semi-darkness. Arriving at the pier, the National Anthem was spontaneously sung by the community. The royal party then went on board the barge, the harbour being lit up by torches. By now *Britannia* was also lit up and after the barge was taken on board she gradually moved off into the darkness. So ended a truly memorable day and one which will be treasured by all who were there.

I left Fair Isle early next morning as I had only a fortnight to complete my preparations before sailing for Montreal. However "the best-laid schemes o' mice and men gang oft agley" and with very little warning the sailing was cancelled owing to the seamen's strike. The shipping company, however, with the minimum of time arranged air transport by Boeing 707 and we completed the journey ahead of time, taking six-and-a-half hours instead of six-and-a-half days. It was a wonderful experience travelling by super-jet at a height of 35,000 feet and a speed of 540 m.p.h. There were 152 passengers and a crew of about fifteen. We had a four-course meal aloft and arrived quite early at Montreal Airport owing to differences in time. After passing through customs and immigration formalities we travelled by bus to Montreal City where I stayed overnight. Next day I travelled to Boston by train, where I was met by my friend who took me to her home in Massachusetts, about twenty miles away.

New England was all very new to me. Of course, I had read about the Pilgrim Fathers and the *Mayflower*, about the Indians and Paul Revere's midnight ride; but now I was actually in the country where so much that is now history took place. It is still difficult to realise that American history is only around three hundred years old; that Americans are a cosmopolitan people and derive directly or indirectly from every country in the world.

Books and Witchcraft

Massachusetts is rich in literary associations and it was a thrill to visit the House of the Seven Gables and Nathaniel Hawthorne's birthplace in Salem; also the Witch House where many innocent people were tried for witchcraft and later condemned to death by hanging—nineteen men and women on Gallows Hill. Visiting Longfellow's Wayside Inn at Sudbury was another memorable experience.

Still another treasured visit was made, this time to the home of Louisa M. Alcott in Concord, to see so many things mentioned in *Little Women* and the furniture and furnishings just as they were in her lifetime.

The weather was very warm during September with temperatures in the 80's and sometimes over 90° F. I was surprised to see peaches and grapes grown out of doors—later the apple-crop came along and I revelled in all the fruit growing at hand. There were many fruits and vegetables which I soon grew to like, such as sweet corn, squashes, egg plant, sweet potatoes, blueberries and cranberries. As lobster is fished around the Massachusetts coast it is a popular item on the menu, also oysters and clams.

I was not long in the U.S.A. ere I discovered that my allowance of £250 would not take me very far, and that if I wanted to carry out my programme I should have to earn some dollars! As I had entered on a visitor's visa it was illegal for me to work for remuneration, so I applied for immigrant status. This is not the work of a day and, in my case, took over five months, but now that I have started work I find it has been well worth while. It really is much better to enter as an immigrant: one can get all the required information so much more easily while in the U.K. and also be spared the anxiety of wondering if ends will meet. Now I can remain in this country indefinitely, meantime notifying any change of address and reporting as an alien annually. Some of my nursing experiences will be related in a later instalment.

In October I had a very welcome invitation to New York City from friends I had met in Fair Isle. This was a dream coming to life and when I eventually arrived at Grand Central Station and was met by my kind friend I simply had to stand still for a moment and try to realise that at last I was in New York. The first morning I went to the Empire State Building and at the 102nd floor looked *down* on all the other skyscrapers. The *Queen Mary* looked so small in her berth and as visibility was unlimited that morning I had a wonderful view of Manhattan Island and its surroundings. This small island, on which New York City is built, was originally bought from the Indians for $24 worth of trinkets. It is of solid rock which allows for those tall buildings and at the same time underground transport.

Just a week before the inauguration of President Kennedy I visited Washington, D.C., on my way to Florida. The weather was all that could be desired—sunny and warm—so very different from the wintery scene a week later. My first visit was to New York Avenue Presbyterian Church where Peter Marshall ministered. Dr. Docherty, the present minister, kindly showed me round and pointed out the beautiful replica of the St. John Cross of Iona. This sanctuary cross was dedicated to the memory of Dr. Peter Marshall and is the gift of the Peter Marshall Scottish Memorial Committee. Abraham Lincoln worshipped in the old building and his pew is now incorporated in the new one.

Margaret Cairns,
S.R.N., S.C.M., Q.N. cert.

NURSING BOOKSHELF

One of Those Children by Elizabeth Neal. (George Allen & Unwin Ltd., price 18s.)

MRS. NEAL has written a gripping book, with distinctive style. There is none of the repetition one might have expected from a mother so closely related with the day-to-day care of her subnormal child and certainly the "maudlin motherhood" which Mrs. Neal so obviously fears may be attributed to her is not present. What rather emerges is a woman of distinctive character who, seeing the implications of her child's handicaps fairly and squarely, then deals with them in a way characteristic of her own personality and development. Mrs. Neal's approach to her boy is not that of many mothers having similar circumstances, and as I read this book it seemed to me that had Mrs. Neal been free from the ties of a dependent child, she would have been equally lone wolf and campaigning for some other cause.

Mrs. Neal shows very definite ideas on the handling of children and the development of the individual within society, and in fact her little boy's personality is greatly influenced by her own sensibilities and attitudes. We find in him responses which are very developed, beyond his innate sufficiencies, and which I feel must at first have been a projection of Mrs. Neal. He has assimilated, as time goes by, these qualities of personality, and they give him a warmth and simplicity of his own.

At the end of the book one admires Mrs. Neal and is humbled by the burden she undertook and the strength and single-mindedness which she has brought to its pursuit. One cannot, however, fail to see that from the emotional pressures of her situation she interpreted certain facets of her child's development and forced herself into an attitude toward life which separated her from the society around her and which must have had repercussions on her husband and normal child.

How can one criticise a task well done and ask for perfection of attitude toward a job which one probably could not do? The question remains, however, in my mind (not, I hope, ungenerously) as to whether Mrs. Neal enjoyed the fight? If she did, it was a worth-while cause.

Mrs. Neal joins the hundreds of heroic mothers of my acquaintance, and I would whole-heartedly recommend her book to all those who wish to understand a little more.

E.F.T.

Protection of the Nurse against Tuberculosis by F. A. H. Simmonds, M.A., M.D., D.P.H. (Chest & Heart Association, price 12*s.* 6*d.*)

THE second edition of this little booklet of some ninety pages should be read by all entering the nursing profession and not only those working in tuberculosis wards or hospitals.

The method of tuberculous infection and the method and significance of tuberculous skin testing is clearly explained.

Practical advice and instruction are given in the prevention of unnecessary infection and the various preventative measures suggested are backed by medical evidence.

B.C.G. vaccination is explained and results discussed.

The book is very readable and has a good bibliography and a number of clear illustrations.

J.W.C.

Counselling and Social Welfare by J. H. Wallis. (Routledge and Kegan Paul, price 12*s.* 6*d.*)

THIS little pocket-sized book is, I think, a "must" for both the lay and the professional social worker and especially for the health visitor.

It describes the kind of people who come for advice and help, and explains, in straightforward language that is free from the usual psycho-therapeutic jargon, how the counsellor should conduct an interview. This makes the reader feel that "casework" need not be surrounded by a mystical aura that only the specially initiated can hope to penetrate. It is encouraging to think that any social worker of good will might learn to do good casework in this way.

The author stresses the fact that counsellors also have their own individual human failings and personal reactions to people and situations. These must first be understood in himself before the counsellor can fully understand his client.

Instead of giving examples from real case histories, the author reports recordings made by students who enacted imaginary interviews during tutorial sessions. Strangely enough these reports seem vivid and more realistic than many of the typical interviews recorded from real life which one normally finds in books of this kind.

The chapter on "Learning how to Counsel" is very practical, with its advice to counsellors to meet their colleagues frequently both for group discussion about common problems and to help them to understand themselves.

There are useful appendices, giving a list of books suitable for background reading, also a "Practical Guide for Counselling" consisting of short notes on "do's and don'ts".

J.K.W.

Basic Principles of Nursing Care by Virginia Henderson (International Council of Nurses, price 3*s.*)

THE scope of this small book is extremely wide—it lays down the care needed by any patient, whatever the diagnosis or treatment prescribed. Its principles apply to any situation since they are concerned with fundamental human needs. The book serves the whole field of nursing; however, it is more relevant to the sick and helpless whether in hospital or at home, than to those whose work mainly emphasises the promotion of health.

The nurse's function is defined as being to assist an individual to perform activities which contribute to health or its recovery—the nurse needing to estimate the patient's immediate and future needs for health of body and mind. The nursing care is expressed first as principles and planned in conjunction with the doctor's treatment, and the patient's normal habits and routine. The author outlines the various states and conditions applying to a patient, and briefly describes how his total needs are met by the nurse in each situation. All needs are basic and include respiration, eating and drinking, position, rest and sleep, clothing, communication with others, practice of beliefs, occupying time with work, recreation and learning.

From this booklet any nurse may gain a clearer understanding of what she is doing for and with the patient, and also how to express this (an exercise seldom undertaken and one we find more diffi-

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Nursing Bookshelf

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cult than the work itself!). It helps to assess our own standards or nursing care. It is stimulating to realise how much this embraces and how much can be accomplished by the nurse to help the individual in his recovery of health—in nearly all cases done by the patient himself. The patient throughout is referred to as one individual, never as part of a group of patients in a ward, emphasising that no generalisation is really possible in planning nursing care.

The given plan of detailed care for a day in the life of a young male patient in hospital does not fit in with our pattern of care in open wards, which applies to all but a very few patients here. This routine would be impracticable, in the main. This is the outstanding item in the book which reminds you that the writer is American; otherwise it is refreshingly brief and one comes across very few of the long terms generally met with in American publications. The price is reasonable and the style easy to read; the sequence makes the context easy to remember.

M.R.S.

The Association of District Nurses

BUCKS., OXON., BERKS. BRANCH

A branch meeting was held on 24th March at 41 Banbury Road, Oxford (by kind permission of Miss H. Longhurst).

After discussion of the minutes and general business matters arising, a report on the last general meeting of the Association was read by Miss B. Moss, our representative.

Afterwards Dr. Williamson, from the Warneford Hospital, Headington, gave us a most informative and colourful lecture on "Drugs used in the Treatment of Mental Illness".

The next branch meeting will be held on Tuesday, 16th May in Aylesbury.

H.Y.W.

BRANCH SECRETARIES
PLEASE NOTE

Will all branch secretaries please send to the honorary secretary of the Association: Miss D. G. Emery, M.B.E., 1 Church Cottages, Emery Downs, Lyndhurst, Hampshire, an *accurate up-to-date list of branch members.*

Miss Emery is circularising secretaries as far as possible, but has not yet been notified of the names and addresses of all branch secretaries for this year.

Queen's Nurses Personnel Changes

APPOINTMENTS

Superintendents, etc.

Burrell, D. M., Asst. Supt., Norfolk—Carter, Mrs. D., Asst. Div. N.O., Herts.—Elliott, P., Supt., Middlesbrough—Goldthorpe, D. M., Div. N.O., W. Riding—Green, E., Supt., Sparkhill, B'ham—Hughes, M., D.N. Tutor, Manchester—Moseley, E., Co. Supt., Glamorgan.

Nurses

Blandford, J. P., Surrey—Chavannes, Mrs. E. M., Herts.—Connolly, M. M., Woolwich & Plumstead—Cottier, M. N., Isle of Man—Crowley, M., Essex—Cubbin, E. J., Isle of Man—El Halawani, B., Hampstead—Englefield, Mrs. T., Berks.—Francalanza, Mrs. J., Surrey—Hiscox, E. M., Gloucester—Ibbett, O. J. E., Beds.—Leckey, Mrs. A. M., Manchester—Lewis, Mrs. J., Shoreditch & Bethnal Green—McLean, Mr. D. W., Norfolk—Mitchell, E., Westmorland—Mullins, Mrs. K. A., Middx. Area 6—Nicholson, G., Berks.—Pearson, J., Hampstead—Smith, Mr. N. J., Beds.—Van Haeften, P. P., Bucks.—Webster, M. E., Berks.

RESIGNATIONS

Barker, Mrs. Y. J., hospital post—Barnett, Mrs. D., domestic—Benson, M. E., domestic—Bryce, Mrs. R., retirement—Cornter, R., retirement—Cruse, Mrs. G. M., hospital post—Dluhy, E. E., work in Australia—Dodd, J., personal—Emerson, Mrs. J., domestic—Fish, V. R., personal—Gill, Mrs. E., personal—Gilligan, C. B., health—Gladwin, E., retirement—Guttridge, Mrs. S. J., domestic—Hardy, J. E., other work—Heywood, Mrs. M., domestic—Jordan, Mrs. A. M., domestic—Lloyd, B. A., marriage—McGowan, A., domestic—McLoughlin, Mrs. J., domestic—Martin, C., marriage—Miller, J., marriage—O'Reilly, P., leaving for Australia—Phaler, Mrs. E. E., domestic—Powell, M., marriage—Reeves, P., Canada—Richardson, J. S., marriage—Ross, F. L., domestic—Smith, D., domestic—Steane, K. A., personal—Taylor, P. L., domestic — Toyn, O., personal — Walley, F. I., hospital post—Walsh, D. G., retirement.

REJOINERS

Baron, Mr. K. A., Lancs.—Bulwer, P., Essex—Edge, Mrs. J. E., Bucks.—Hurst, B., Plymouth (Asst. Supt.)—Kearsey, E., N. Riding—Thomas, M. E., W. Riding.

Scottish Branch

APPOINTMENTS

Nurses

Carter, F. A., Glenboig—Gilland, A. C., Hamilton—Hourston, M., Hoy & Walls—Isdale, G. C., Auchmuty—MacInnes, C. M., Carbost—MacLeod, J. R. M., Shieldhill—Martin, C., Miavaig, West Uig—Nicolson, M. A., Mallaig—Stangoe, J. H. P., Hamilton.

REJOINERS

Campbell, Mrs. M. D., Kilbrandon—Louden, E., Kilmacolm—Macfarlane, J. S., Motherwell—MacKenzie, M. M., Glasgow.

RESIGNATIONS

Beaton, I., Dunvegan, marriage—Erwin, M., Kilsyth, work abroad—Harris, A. L., Ayrshire, marriage—Harvey, S., Peterhead, marriage—Kerr, M. J., Glasgow, work in hospital—MacDougall, R., Leadhills, Bible study course—Macfarlane, Mrs. K., Cromarty, marriage—MacIver, C., Back, marriage—MacKenzie, A., Carbost, marriage—Macleod, K., Greenock (Supt.), home reasons—MacLeod, M., Aird, marriage—Paterson, B., Arbroath, home reasons—Shearer, J., Shieldhill, marriage—Shields, Mrs. M., Bellshill, other work—Sowler, I., Gullane, retired—Watson, E. G. R., Biggar, marriage—Winton, Mrs. B. J., Edinburgh, marriage.

TRANSFERS

Brugger, E. M., Glasgow (Bath St.), to England—McDougall, I. J., Renfrew, to England—Ramsay, C., Glasgow (Govan) to Ireland.

Obituary

Miss Florence Bell

IT was with great grief that we in Devon learned of the death of Miss Florence Bell on March 17th; she was 92.

Miss Bell came to Devon in 1904, and with only a few nurses at her disposal she started the tremendous task of providing a district nurse in every parish. The task involved endless journeys by train, cycle, and on foot over this large county; many battles with committees were fought to procure the best possible conditions for her nurses. She had a Florence Nightingale quality which made her mistrust insincerity, and she was a born fighter.

When Miss Bell retired in 1934 she had, in her thirty years of hard work, achieved magnificent results.

On retirement, she lived in my road, and I came to know her as a neighbour and friend. She spent much time visiting the old, and sick people living alone, while her tea parties for children were famous!

Finally, I knew her as a patient, and she bore pain and near blindness with much patience; till the end she was interested in everything appertaining to nurses. She was an example to us all, and her memorial is surely the work being done today. May she rest in peace.

E.M.S.

Memorial

AT a short service conducted by the Rev. A. D. Stirling, a seat was unveiled in memory of the late Miss Isabella Williamson on Sunday, 19th February at The Loan, South Queensferry, West Lothian.

Miss Williamson had been Queen's nursing sister in South Queensferry for almost seven years before her death.

The money for the seat was raised by public subscription and the balance is to be used in presenting an annual prize in two of the local schools. This gesture is proof of the high regard in which Miss Williamson was held by the community.

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.

Rates: Displayed Setting: 17s. 6d. per single column inch: £2 per double column inch. Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.). Ruled border 5s. extra

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EAST LOTHIAN
COUNTY COUNCIL

County Nursing Superintendent

Applications are invited from suitably qualified persons for above post which will shortly become vacant. Applicants should have training of the Q.I.D.N. and hold Health Visitor's Certificate. The work includes supervision of the Council's District Nursing and Health Visiting Services, various functions connected therewith, and certain duties connected with the Home Help Service. Applicants should have administrative ability and experience and must be able to drive a car. Salary and other conditions of service in accordance with national agreements.

Applications, with full details of previous experience and qualifications and names of two referees, to County Medical Officer, County Buildings, Haddington, within fourteen days.

CITY OF OXFORD
HEALTH DEPARTMENT

Assistant Superintendent for Queen's Training Home

Experienced Queen's Sister required to act as District Nurse Tutor (up to eight students, study-day system of training) and to deputise for the Superintendent in her absence. Must hold Health Visitor's Certificate. Motorist essential. Resident or non-resident. Salary according to Nurses and Midwives Whitley Council. Application forms obtainable from the Medical Officer of Health, Health Department, Greyfriars, Paradise Street, Oxford, to whom they should be returned.

HARRY PLOWMAN
Town Clerk

Town Hall, Oxford

METROPOLITAN
DISTRICT NURSING ASSOCIATION

Applications are invited for the post of **Second Assistant Superintendent** at the above training home. H.V. certificate essential. Resident preferred. Good experience in administration and teaching. Apply: Superintendent, 18–20 Montague Street, Russell Square, London, W.C.1.

MIDDLESEX COUNTY COUNCIL
COUNTY HEALTH DEPARTMENT

Matron (res.) required at Belle Vue Mother and Baby Home, 167 Willesden Lane, N.W.6, for twelve post-natal unsupported mothers and babies. Must be S.R.N. and S.C.M. Experience with mothers and young babies desirable. Provision for uniform. Salary £704–£887 less £205 for board and lodging. Established. Prescribed conditions. Particulars and two referees to County Medical Officer, Ref. "S", 3, 5 and 7 Old Queen Street, S.W.1, by 29th June. (Quote G.124 D.N.J.)

WARWICKSHIRE COUNTY COUNCIL

Deputy Area Nursing Officer

Applications are invited for the appointment of Deputy Area Nursing Officer in the Central Area. (Office at Leamington Spa.)

Salary scale £814×£31 to £876×£32 to £940.

The Officer appointed will be required to undertake relief duties and to assist in the administration of midwifery, general nursing, health visiting and school nursing.

The appointment will be subject to the Local Government Superannuation Acts, 1937–1953, and to the production of a satisfactory medical certificate.

Furnished or unfurnished accommodation available and consideration will be given to the granting of financial assistance towards removal expenses.

Full particulars and application forms (which must be returned by the 17th May, 1961) can be obtained from the County Medical Officer of Health, Shire Hall, Warwick.

L. EDGAR STEPHENS
Clerk of the Council

Shire Hall,
Warwick.
April, 1961

SOUTHWARK,
NEWINGTON AND WALWORTH
DISTRICT NURSING ASSOCIATION

65 Sancroft Street, S.E.11

Non-Training Home Staff approx. 22
Assistant Superintendent required 1st October 1961. Furnished or unfurnished accommodation in annexe. Non-resident.

COUNTY BOROUGH OF
SOUTHEND-ON-SEA

Appointment of District Nurse (Female)
Public Health Department

Applications are invited for the above appointment. Salary in accordance with the award of the Whitley Councils for the Health Services. Must be S.R.N. District nurse training would be an advantage.

Full particulars and application forms obtainable from the Medical Officer of Health, Municipal Health Centre, Warrior Square, Southend-on-Sea, to whom they should be returned within three weeks of the appearance of this advertisement.

ARCHIBALD GLEN, Town Clerk

CITY OF OXFORD

District Nursing Service

Queen's Nursing Sister for general nursing only. Resident or non-resident, car driver or cyclist. Consideration is being given to the possibility of attachment of a nurse to general practice.

Student Queen's Nurses—vacancies for S.R.N., S.C.M.'s, to take three months course of District Training commencing September, 1961.

Applications to Superintendent, 39/41 Banbury Road, Oxford.

BUCKINGHAMSHIRE COUNTY COUNCIL

Midwifery and Home Nursing Service

Applications are invited for the following posts. District Nurse trained an advantage. Accommodation may be furnished or unfurnished. Present holiday arrangements honoured. Cars provided or allowance given for own car.

Assistant Superintendent for:

Slough Nurses' Home (Housekeeper employed). District Nursing and Domiciliary Midwifery undertaken. Affiliated Part II Training School for pupil midwives. Duties include supervision of District Nurses and Midwives in South Bucks. Facilities available to take the Midwife Teachers Diploma. Salary scale: £730 to £861 per annum, less £225 per annum for board lodging.

District Nurse/Midwives for:

Chalfont St Peter and **Chalfont St Giles.** Suitable for friends. House available. Car drivers essential.

Iver Heath. Rural area. House available. Car driver essential.

Newport Pagnell. Six-roomed house available. Light midwifery case load. Car driver or willing to learn.

District Nurse/Midwife/Health Visitors for:

Tingewick (North Bucks.). House nearing completion. Car driver essential.

Whitchurch (near Aylesbury). House available. Car driver essential.

Area Relief Nurses (Graded District Midwives) for:

Westcott and **Winslow.** To relieve groups of four or five nurses in rural areas for holidays and sickness, and when not engaged on these duties for weekly and monthly off-duty. New housing accommodation available. Car drivers essential.

Holiday Relief Nurse/Midwives for short or long periods.

Queen's District Training Course:

State Registered Nurses with the S.C.M. Certificate for three months' course arranged by the Queen's Institute of District Nursing. Candidates undertake to work in Buckinghamshire for a period of one year on completion of training. Course commences last week in May or September.

Further particulars and application forms available from: County Medical Officer, County Health Department, County Offices, Aylesbury, Bucks.

EAST LOTHIAN
COUNTY COUNCIL

District Nurse, Gullane

Applications invited for post of **District Nurse** in Gullane area. Applicants should have training of Q.I.D.N. and preferably be able to drive car. Salary and conditions on national scales and furnished accommodation provided at appropriate deduction.

Applications to County Medical Officer, County Buildings, Haddington, within fourteen days.

Other Advertisements on p. 46 and 47

DEVON COUNTY COUNCIL

(Member of Queen's Institute)

District Nurse/Midwives, preferably with Queen's training, required in the following areas. Cars supplied or allowance given for the use of own. Whitley Scale of salary and conditions of service.

Anstey, rural area, near South Molton	Lodgings, house later
Barnstaple, north Devon	Flat available
Brixham, south Devon	Flat available
Dartmouth, south Devon	Double district, house available, suit two friends: or two separate flats
Hartland, north Devon	House available
Horrabridge, near Tavistock, south Devon	Lodgings. House or bungalow available later
North Molton	House available
Parkham, near Bideford, north Devon	Lodgings. House or bungalow available later
Plympton (2)	Flat available for one. Own arrangements or lodgings for one
Tiverton, east Devon	Double district, bungalow available, suit two friends
Whiddon Down, near Okehampton, mid-Devon	House available

Apply for conditions to the

County Medical Officer, 45 St. David's Hill, Exeter

BRECONSHIRE COUNTY COUNCIL

Public Health Department

Applications are invited for the following posts which have or will become vacant on account of re-organisation of Nursing Areas and to replace existing staff due to retire.

(1) **Health Visitor/School Nurse**
- (*a*) Builth Rural (Llanwrtyd and Beulah Areas)

(2) **District Nurse/Midwife**
- (*a*) Brecon Urban and Rural Area (Talybont District)
- (*b*) Hay Urban and Rural Area (including Llanigon)
- (*c*) Builth Rural (Llanwrtyd and Beulah Areas)

(3) **District Nurse/Midwife—Area Relief (Permanent)**
- (*a*) Brecon Urban and Rural Area
- (*b*) Brynmawr Urban and Crickhowell Rural (Part) Area

Applicants for the Health Visitor's appointment must be qualified Health Visitors, and applicants for the other appointments must be S.R.N. and S.C.M. with or without district training.

Scholarships are offered to suitably qualified nurses for training as Queen's Nurses and/or Health Visitors.

The District Councils do all they can to see that nurses in their areas are allocated houses. Houses are immediately available for the District Relief Nurse/Midwife, Brecon Area, and the District Nurse/Midwife for the Hay Urban and Rural Area.

Forms of application and further particulars can be obtained from the County Medical Officer, Health Department, Watton Offices, Brecon, and should be returned within two weeks of the appearance of this advertisement.

GLOUCESTER DISTRICT NURSING SOCIETY

State Certified Midwives required for whole-time domiciliary midwifery. Also one domiciliary midwife required for night-duty only. Apply to the Superintendent, 14 Clarence Street, Gloucester.

CUMBERLAND COUNTY COUNCIL

(Affiliated to the Queen's Institute of District Nursing)

1. **District Nurse/Midwife/Health Visitors**
   - (*a*) **Bothel**—One required
   - (*b*) **Threlkeld** (near Keswick)—One required
   - (*c*) **Wigton**—One required
   - (*d*) **Alston**—Two required } Suit
   - (*e*) **Longtown**—Two required } friends
2. **District Nurse/Midwives for Maryport**—Two required. Suit friends.
3. **District Midwife for Millom**—One required. New flat available.

Furnished or unfurnished houses available and cars will be provided for all the above appointments.

4. **Queen's District Training**—Applications are invited from nurses S.R.N., S.C.M., wishing to work as district nurse/midwives in Cumberland. Arrangements can be made for them to take three or four months' training at an approved Queen's Nurses' Training Home.

Further particulars and application forms obtainable from the County Medical Officer, 11 Portland Square, Carlisle.

PEMBROKESHIRE COUNTY COUNCIL

Milford Haven and **Hakin.** Two District Nurse/Midwives required for mid-June. Large or small flat available, furnished or unfurnished. Would suit friends. Car or car allowance will be provided. Vacancies caused by marriage.

Application forms obtainable from County Medical Officer, County Health Department, 23 Hill Street, Haverfordwest.

METROPOLITAN DISTRICT NURSING ASSOCIATION

District Midwife required for Central London area. Resident in nurses' hostel. Cyclist or motorist. Apply: Superintendent, 18–20 Montague Street, Russell Square, London, W.C.1.

WARWICKSHIRE COUNTY COUNCIL

Applications are invited for the undermentioned vacancies. Where house or other accommodation available this can be either furnished or unfurnished. Consideration will be given to the granting of financial assistance towards removal expenses and for driving tuition. Motorists can receive allowance for own car or car will be provided.

District Nurses, District Midwives, District Nurse/Midwives

Area 2*a*–**Atherstone** (rural). One district nurse/midwife. Motorist. House suitable nurse with relative.

Bedworth (urban) district midwife. Motorist. House,

Area 4—**Coleshill and District** (urban and rural). District nurse/midwife. Motorist. Flat.

Castle Bromwich and District (urban). District nurse/midwife. Motorist. House.

Kingshurst (urban). District nurse/midwife. Motorist. House.

Wilnecote and District (urban and rural). District nurse/midwife. Motorist. Flat.

Area 6—**Warwick and District** (urban and rural). District nurse/midwife. Motorist. Accommodation.

District Nurse/Midwife/Health Visitors

Area 3—**Birdingbury** (rural). One required. Motorist. Modern flat.

Clifton-on-Dunsmore (rural). One required. Motorist. Modern flat.

Area 6—**Fenny Compton** (rural). One required. Motorist. House.

Bishops Itchington and District (rural). One required. Motorist. House.

Health Visitors

Area 2*a*–**Bedworth** (urban). One required. Motorist.

Application forms and full particulars may be obtained from the Area Medical Officer as follows:

Area 2*a*—Health Department, Council House, Nuneaton; Area 3—Health Department, Albert House, Albert Street, Rugby; Area 4—Health Department, Park Road, Coleshill, Birmingham; Area 6—38 Holly Walk, Leamington Spa.

The Council is a member of the Queen's Institute of District Nursing.

L. EDGAR STEPHENS
Clerk of the Council

Shire Hall,
Warwick.
April, 1961

COUNTY BOROUGH OF SOUTHEND-ON-SEA

Male District Nurse

Applications invited for the post of male district nurse.

Whitley Council salary and conditions of service.

Assistance with housing.

Car allowances or transport provided.

Arrangements for payment of removal expenses.

Forms of application can be obtained from the Medical Officer of Health, Municipal Health Centre, Warrior Square, Southend-on-Sea, to whom they should be returned within three weeks of the appearance of this advertisement.

ARCHIBALD GLEN, Town Clerk

SOMERSET COUNTY COUNCIL

Midwifery and Nursing Services

Health Visitors (2)

Yeovil. Duties consist of maternity and child welfare and school work in borough. To work in group of four health visitors.

Combined Posts. S.R.N., S.C.M., H.V., preferably with Queen's district training or willing to train. Scholarships awarded for H.V. certificate. Cars available. Financial help given with driving tuition.

Bleadon. Adjoining Weston-super-Mare. Single district. Accommodation available, house to be built shortly.

Batheaston. Adjoining Bath. Single district in group of four nurses. House available.

Pilton. Near Shepton Mallet. Single district. House available.

Wraxall. Near Bristol. Single district. House being built shortly.

Yatton/Cleeve. Near Clevedon and Bristol. House being built shortly.

Beckington/Rode. Near Bath. Single district. Bungalow being built.

Nurse/Midwives required, S.R.N., S.C.M. preferably with Queen's District training or willing to train. Bicycles or cars available.

Clevedon. Near Bristol. Own living arrangements.

Montacute. Relief nurse for group of four nurses. Accommodation available, house to be built later.

Shepton Mallet. Relief nurse for small group of nurses.

Paulton/Timsbury Area. Nurse required for group of nurses. Accommodation available.

Taunton. Accommodation in nurses' home or can make own arrangements.

Yeovil. Nurse/midwife urgently required.

For further particulars apply to: County Medical Officer of Health, County Hall, Taunton.

QUEEN'S INSTITUTE OF DISTRICT NURSING

Health Visitor and District Nurse Training Courses

1961–1962

Health Visitor Course.

1. Nine months' course approved by the Minister of Health to prepare students for the health visitor's examination of the Royal Society of Health. Courses are held at the Bolton and Brighton Technical Colleges and begin in September.

District Nurse and Health Visitor Course.

2. Courses covering thirteen months to prepare students for:

(*a*) The national certificate of the Ministry of Health and the certificate of the Queen's Institute (district nursing).

(*b*) The certificate of the Royal Society of Health (health visiting).

Three months' course in district nursing is taken at approved centres, beginning May/June 1961, and may be followed immediately by nine months' health visitor course beginning in September 1961.

Further information and details may be obtained from the organising tutors at:

1. Bolton Technical College, Manchester Road, Bolton;

2. Arts and Social Studies Department, Brighton Technical College, 237 Preston Road, Brighton.

HEREFORDSHIRE COUNTY COUNCIL

Combined Health Visitor/District Training

Scholarships are offered at recognised training centres to S.R.N., S.C.Ms. Generalised duties, home nursing, midwifery and health visiting to follow for two years on completion of training. Grant during Health Visitor's training of 75% of Health Visitor's salary scale plus tuition and examination fee.

Appointments

Applications are invited for the following appointments:

Pontrilas—South-west Herefordshire—**District Nurse** for generalised or combined duties according to qualifications. New house, furnished or unfurnished. Motorist —car provided or allowance for own car.

Hereford—District Nurse/Midwife or **Midwife.** Modern house, furnished or unfurnished. Motorist or willing to learn.

Application forms and terms of scholarships and appointments may be obtained from the County Medical Officer, 35 Bridge Street, Hereford.

COUNTY BOROUGH OF SOUTHEND-ON-SEA

Student Health Visitors

Applications invited for appointment as student health visitors to commence September next.

Free choice of training centre.

One year's post-qualification service with the authority required.

Health, school health and welfare functions fully integrated in the department.

Salary £516 per annum with adequate loan for educational expenses, part only of which is repayable during post-qualification year of service.

Forms of application from the Medical Officer of Health, Municipal Health Centre, Warrior Square, Southend-on-Sea.

ARCHIBALD GLEN,
Town Clerk

QUEEN'S NURSES' BENEVOLENT FUND

The Annual Meeting and Bring-and-Buy Sale will be held on Friday, 16th June 1961 at 3 p.m. at the Metropolitan District Nursing Association, 18–20 Montague Street, Russell Square, London, W.C.1.

Gifts in money or kind will gladly be received by Miss E. E. Loynes, Superintendent of the home, for the Bring-and-Buy Sale. Subscribers and friends are asked to give their support to this effort.

Your Route: Buses nos. 19 from Clapham Junction; 38 from Victoria; 68 and 196 from Waterloo; 68 from Euston.

Underground Stations: Russell Square, Holborn and Tottenham Court Road.

NEW AUSTIN CARS

Reduced Hire Purchase and Insurance rates to members of Nursing Profession. Seven, A.40 and A.55 Saloons from £108 1*s* 4*d* down, 36 monthly instalments £14 4*s* 7*d*. Also Morris Minor and Mini-Minor Saloons. Free Brochures. Austin House (D.N.), Highfield, London, N.W.11.

QUEEN'S INSTITUTE OF DISTRICT NURSING

William Rathbone Staff College

Course in Community Health Administration

Applications are invited from General State Registered Nurses who are (a) district nurses, midwives or health visitors with at least three years' experience in the field; or (b) hospital sisters with at least three years' post-certificate experience who wish to gain a wider knowledge of public health nursing, for the three-month residential course begining on Thursday, 14 September, 1961.

Scholarships are available for nurses from Co. Durham, Sunderland, London and other areas.

Further details may be obtained from The Principal, William Rathbone Staff College, 1 Princes Road, Liverpool 8.

THE FLORENCE NIGHTINGALE FAIR

At Chelsea Town Hall Wednesday 24th May 10.15 a.m. to 7 p.m. and Thursday 25th May 11 a.m. to 7 p.m.

New WHO publication

UNDER the title *Aspects of Public Health Nursing* the World Health Organisation has just published the fourth volume in its series Public Health Papers.

This series is a medium for the publication of occasional papers that have usually been prepared as contributions to the study by W.H.O. of a particular health question, and that are considered to be of interest to a wider circle of readers than those for whom they were originally written.

The purpose of Public Health Papers is to stimulate international thinking, discussion, and planning by the publication of the personal ideas, observations, and suggestions of individuals or groups.

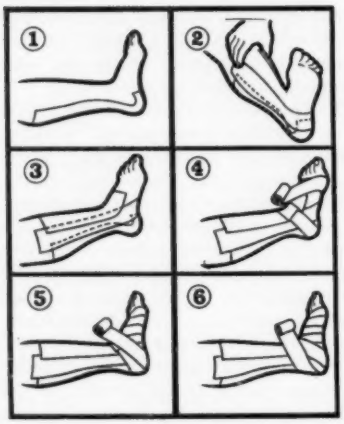
Aspects of Public Health Nursing is a collection of thirteen papers on various aspects of public health nursing. The contributors are nurses, social scientists, doctors and an administrator. Many have had extensive international experience. The nurse's responsibility in health teaching, public health nursing in the basic curriculum, the team in public health nursing, the role of the midwife in public health and how custom and culture affect the work of the nurse are among the subjects discussed. The work and training of the assistant sociale in France and the feldshers and nurses in the U.S.S.R. are described.

Public Health Papers will appear at irregular intervals. The price is 8*s*. 6*d*., U.S. $1.25, Sw.fr. 5, with a fifty per cent discount on orders for ten or more copies. Postage extra. Available from the Distribution and Sales Unit, World Health Organisation, Palais des Nations, Geneva, Switzerland.

Rehabilitation

OF THE VARICOSE ULCER PATIENT

Sitting around in chairs—or with the foot raised—is unlikely to help in the healing of a varicose ulcer, and should be discouraged.
Patients will tell you that there is less pain if they walk about. This is made possible with compression bandaging. Ambulation assists in squeezing the oedema fluid away from the lower leg and materially assists and hastens the healing processes. For compression bandaging, elastic adhesive bandages, such as 'Lestreflex' ventilated or fully spread, or 'Dalzoflex' are routine.



TECHNIQUE:

A firm 'Lestreflex' or 'Dalzoflex' support may be kept on for 3 to 30 days according to the condition and discharge of the ulcer and the amount of swelling in the leg. A strip of bandage is passed under the heel and up each side of the leg. Another strip is laid over the tendo-Achilles—and a third in front of the ankle. Then a bandage is wound with considerable tension round the foot and leg, starting from just behind the clefts of the toes, ending just below the knee, and fully enclosing the heel.
Use 'Dalzoband' Paste Bandages under the support bandage as may be ordered if the eczema is severe.

LESTREFLEX

FULLY SPREAD OR VENTILATED

ELASTIC DIACHYLON BANDAGE B.P.C./N.H.S.

DALZOFLEX

FULLY SPREAD OR VENTILATED
ELASTIC ADHESIVE BANDAGE B.P.C./N.H.S.

Samples and Literature on request to:
DALMAS LIMITED · (DEPT. 15), 215 CHARLES STREET · LEICESTER

Zoflora

floral **DISINFECTANT**

SWEETENS AND FRESHENS THE SICK ROOM

Zoflora Floral Disinfectant is not only a powerful germicide, used in a spray it freshens and sweetens the atmosphere whilst helping to prevent the spread of infection.

Zoflora Aerosol in Bouquet and Lavender 3/9d. each

Zoflora Concentrate in Bouquet, Lavender, Carnation, Jasmin, Lilac, Rose, Sweet Pea, Wallflower, Eau de Cologne and Pine, 2/6d. per 2 oz. bottle.

THORNTON & ROSS LTD · HUDDERSFIELD.

TZ 84

GOING ON HOLIDAY?

The Crusader "Family Holiday Policy" protects you and your family against —

- ★ LOSS OF HOLIDAY DEPOSITS
- ★ LOSS OR DAMAGE TO BAGGAGE
- ★ LOSS OF MONEY
- ★ MEDICAL EXPENSES
- ★ EXTRA EXPENSE DUE TO STRIKES ETC.
- ★ PERSONAL INJURY

ASK FOR FULL DETAILS OF THIS VALUABLE YET INEXPENSIVE PROTECTION

Crusader Insurance Co. Ltd.

Established 1899

CHIEF LONDON OFFICE: 52 LIME STREET, E.C.3
Telephone: MANsion House 4851

napkin rash *(urinary ammonia dermatitis)* appears when the natural acid balance of baby's skin is upset.

napkin rash disappears (or won't even start) if baby's is gently massaged with Natusol.

Natusol (a recently developed Danish discovery) keeps baby comfy—by maintaining the natural acid balance of his skin . . . and safe-guarding it against harmful, irritating alkali, ammonia and germs.

Long lasting freedom from excessive skin alkalinity is achieved by the use of this apparently simple formulation: Acid Boric 2.85, Borax 0.15, Glycer. 10.62, Paraff. Liq. 10, Paraff. Moll. Alb. 55.2, Adeps Lan. 20.

For more detailed information regarding Natusol apply to **THOS KERFOOT & CO. LTD.,** *(Dept., DN)*
Vale of Bardsley, Ashton-under-Lyne.

natusol

From chemists 2/9d per tube

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Nursing